Baystate
Medical Center
A Member of Baystate Health System
Springfield, Massachusetts 01199
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June 20, 2011

Seena Carrington
Acting Commissioner
Executive Office of Health and Human Services
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

Subject: **Testimony for Public Hearing on Health Care Provider and Payer Costs and Trends**

Dear Ms. Carrington:

In response to your May 27, 2011 letter, we have prepared the following written testimony. The deadline for providing a response to your letter was very short and some of the requested information was not readily available in the format requested. Accordingly, the testimony submitted below has been prepared based on reasonable inquiry and is true and correct to the best of our knowledge, information and reasonable belief.

Division of Health Care Finance & Policy Questions and Baystate Medical Center (BMC) Testimony

1. After reviewing the preliminary reports located at *www.mass.gov/dhcfp/costtrends*, please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.

   The data provided in the DHCFP preliminary reports reflect Baystate Medical Center (BMC) as a tertiary care hospital with Medicaid volume which is the third highest in the State as a percentage of total volumes. However, despite the financial challenges of maintaining the services required of a tertiary care hospital and the low payment rates for services provided to Medicaid patients, the prices paid to BMC by private health plans for commercially insured patients are among the lowest in the State. For the selected DRG's in the report, BMC was paid below the median price for two-thirds of the DRG's, with some prices more than 15% below the median. There were no instances in which BMC was paid more than 7% over the median.

   BMC's prices potentially could be even lower if some of the systemic payment issues are addressed. For example, both Medicaid and Medicare payment rates are inadequate to cover the cost of services provided and therefore prices negotiated with private health plans for commercially insured patients must compensate for those shortfalls. Another example is

medical education which requires long term commitments by organizations like BMC, yet the payment streams to support the program are not sufficiently solidified.

The report's Medicaid analysis is based on fiscal year 2009 payment rates. While those rates reflect the first year of Medicaid rate cuts implemented by the Patrick administration, more followed in fiscal years 2010 and 2011. And still more cuts are planned for fiscal year 2012. Hospitals also incur additional financial losses related to care for low-income patients due to significant funding shortfalls in the commonwealth's Health Safety Net program. Hospitals alone are responsible for paying for the shortfall, which totaled $70 million in fiscal year 2010 and which we estimate will approach $120 million in fiscal year 2011.

2. How much have your costs increased from 2005 to 2010? (Percents by year are fine.)
   a. Please list the top five reasons for these increases, with the most important reason first.

Annual Change	Percentage
FY2005 – FY2006	7.53%
FY2006 – FY2007	5.21%
FY2007 – FY2008	4.48%
FY2008 – FY2009	2.50%
FY2009 – FY2010	2.29%

BMC's average annual increase in cost between FY2005 and FY2010 was 4.79%.
As noted above, fiscal years 2009 and 2010 annual increases were only 2.5% and 2.29% respectively.

The top five reasons for these increases between FY 2005 and FY 2010 are listed below.

- Wages increased by 37.2% for the following reasons:
  - Wage increases of 24.2% (an average annual increase of 4.84%). BMC, not unlike other healthcare providers, has suffered a shortage of nursing and allied health employees. The market for pay within these job categories has rapidly accelerated. In order to retain staff and recruit for open positions, BMC has had to accelerate the pay levels in these job categories to remain competitive in the market, retain existing staff, and recruit for open positions.
  - Hospital FTEs increased 13% (642 FTEs). Most of this increase is in nursing, technicians and specialists who have higher than average wages.
- Fringe benefits increased by 36.2% (an average annual increase of 7.2%) primarily due to increases in health insurance premiums; pension plan cost and employer portion of payroll taxes.
- Patient volume and service mix, as measured in case mix adjusted discharges (outpatient adjusted), increased 23.79% (an average annual increase of 4.8%). The increase in volume and case mix has a direct impact on patient supplies, drugs and other expenses.
- Other non-labor cost has increased 13.05% (an average annual increase of 2.61%). Our other non-labor cost has increased based on inflation.

3. What specific actions has your organization taken to contain health care costs? Please also describe what, if any, impact these strategies have had on health care costs, service quality,

and patient outcomes. What current factors limit the ability of your organization to execute these strategies effectively?

BMC has always focused on cost control. Many of the cost control initiatives we have implemented are detailed below. Our ability to effectively execute these and other cost control strategies is limited by our ability to fund operating and capital investments.

Some of our specific cost control initiatives are:

- Reduction in unit costs (Management of cost per unit of service delivered).
  - Consolidation of administrative and support functions where appropriate.
  - Supply chain initiatives (vendor pricing, supply standardization, etc.).
  - Pharmacy cost reductions (including utilization of the 340B drug pricing program).
  - Best practice functional benchmarking and productivity reviews.
  - Maximizing staffing efficiency by matching patient flow with nurse staffing requirements, etc.
  - Re-designation of Magnet Hospital status for excellence in nursing in 2010. Only 2% of hospitals have received consecutive designations like BMC. Magnet status recognizes excellence in a variety of areas including nursing management, philosophy and practices, and adherence to standards for improving quality of patient care, which helps to reduce costs.

- Utilization management (Management of amount of services delivered per episode of care):
  - Through a physician directed approach, BMC has reduced unnecessary utilization while applying evidence based medicine to achieve high quality at low costs.
  - BMC has implemented a program to utilize hospitalists to better manage inpatient care in a cost-effective manner
  - BMC has employed physician directed performance improvement teams to review evidence, utilization data and create guidelines and decision support tools to drive quality and cost reduction.
  - Each year BMC benchmarks costs against 600 hospitals and sets specific goals to reduce overuse within the inpatient setting.
  - BMC has been a leader in the use of Electronic Medical Record's (EMR) for many years which has resulted in increased reliability, quality and safety, and reduced unnecessary diagnostic testing. This has resulted in millions of dollars of reduced costs.
  - Related to EMR, we have achieved over 95% physician utilization of electronic order entry, which is among the leaders in the United States.
  - Most recently BMC has employed LEAN thinking to reduce process waste through LEAN techniques.
  - BMC was designated as a 2010 Leapfrog Group Top Hospital, putting the medical center in an elite group of the safest hospitals in the country.
  - In 2011, BMC was once again designated as a Thomson Reuters Top 100 Hospital, Major Teaching Hospital in the US. This is the third time BMC has received this recognition.
  - BMC has been recognized for excellence in critical care by receiving a fifth Beacon Award, the only Intensive Care Unit in the US to have achieved this honor.

- Wellness programs, disease management and appropriate care setting (Development of programs for prevention and to properly match care needs to the proper setting and delivery of that care). BMC is committed to improving health care delivery and providing programs and services that address the identified health and wellness needs of its constituencies and communities served:
    - In the spring of 1996, BMC and other key stakeholders established Partners for a Healthier Community, a nonprofit organization committed to building a measurably healthier Springfield. BMC has underwritten the mission of the organization, investing $2.7 million. In turn the organization has leveraged this investment earning over $5.7 million from other sources for a total contribution of $8.4 million in community health improvements to address unmet health needs in vulnerable populations and ethnically and culturally diverse communities.
    - In 2007, the Massachusetts Department of Public Health approved BMC's Determination of Need (DoN) application for its Master Facility Plan. In accordance with DoN Factor 9 requirements, BMC developed a plan to provide an array of new or additional community based services. BMC committed $9.6 million over a seven-year period or $1.3 million per year for the provision of health education and preventive health care services to improve population-based health in the project's service area.
    - BMC's community outreach services include three full service community health centers and Western Massachusetts' largest Ob/Gyn clinic.

BMC has taken proactive steps to improve the health of our employees through our Baystate Healthy wellness programs. Baystate Healthy includes health risk assessments, screenings and consultations, fitness, stress management, smoking cessation, nutrition/weight management, better sleep and other programs. Because we strongly encourage wellness, our health plans provide free well care visits.

4. What types of systemic changes would be most helpful in reducing costs without sacrificing quality and consumer access? What systemic actions do you think are necessary to mitigate health insurance premium growth in Massachusetts? What other systemic or policy changes do you think would encourage or help health care providers to operate more efficiently?

Outlined below are various systemic changes that would be helpful in reducing cost trends without sacrificing quality and access. They include treatment of routine care at less expensive settings, such as a primary care practice.

- Administrative Simplification:
    - Standardize and simplify authorization and referral rules.
    - Uniform ID cards that clearly identify plans and their products.
    - Standardize eligibility response systems.
    - Health plans should have pre-established limited time period to retroactively review prior approved claims.
    - Denial remark codes related to national coding standards should be uniformly used by all health plans.
    - Health plans should give appropriate prior notification of any changes in their policies and procedures.
    - Health plans should fully disclose their claims processing logic.

- Standardized reporting requirements to improve productivity and reduce cost.
- A single entity responsible for credentialing providers one time on behalf of all plans.
- A single entity responsible for determining the medical efficiency of clinical interventions for all plans.

- Reduction in Clinical Variation and Utilization:
  - BMC has undertaken many initiatives to reduce clinical practice variations thus improving quality and reducing costs. This concept should be fully expanded to care provided outside of the hospital through the development of continuum of care practice guidelines.
- Increase Access to Primary Care:
  - Access to primary care will reduce unnecessary costly visits to the hospital emergency room for primary care services and reduce the progression to more acute stages of an illness through early detection.
- Investment in Consumer Education & Wellness:
  - Public health driven initiatives to improve population-based wellness and disease prevention and disease management programs.
- Payment and Care Delivery Reform:
  - Creation of "medical homes" and "accountable care organizations" that manage the full continuum of care and are accountable for the cost and quality of care for a defined population.
  - Disease management initiatives.
  - Implementation of EMR to drive reliability for quality and reduce unnecessary diagnostic testing
  - Reduce government mandates
  - Better control of pharmaceutical cost through use of generic drugs, etc.
  - Tort reform related to malpractice awards
  - Implement hospital industry's alternative proposal in lieu of mandatory nurse staffing ratios.

5. What do you think accounts for price variation across Massachusetts providers for similar health care services? What factors, if any, should be recognized in differentiated prices?

   Price variations across Massachusetts hospitals for similar health care services are the result of many factors including:

   - Differences in hospital cost of patient care (including wage levels, cost of technology and other facility costs) that have been negotiated into payer contract rates
   - Differences in quality care that have been negotiated into payer contract rates
   - Differences in market position or market share
   - Differences in Medicaid case load
   - Hospitals' ability to negotiate payer rates to cover government shortfalls
   - Level 1 Trauma Center
   - Level III NICU
   - Teaching status

   The following factors should be recognized in differentiated prices:

   - Levels of quality patient care
   - Government shortfalls

- Cost of educating the next generation of physicians
- Cost of educating the next generation of nurses and allied health professionals
- Case and service mix difference not fully recognized by DRG grouping and related weights
- Technology when supported by patient volumes
- Level 1 Trauma Center
- Level III NICU

6. What policy or industry changes would you suggest to encourage treatment of routine care at less expensive, but clinically appropriate settings? (Routine care is defined here as non-specialty care that could be provided at a community hospital or in a community setting.)

   We suggest the following policy or industry changes:
   - Develop and implement a statewide strategy to recruit primary care physicians and expand primary care capacity in the state.
   - Address primary care access problems by encouraging alternative care sites and after-hours options to hospital emergency departments.
   - Creation of "medical homes" and "accountable care organizations" that manage the full continuum of care and are accountable for the cost and quality of care for a defined population.
   - The MassHealth Programs eligibility structure should allow for certification of special circumstances related to an elder or disabled person who do not meet the requirements for coverage under one of the current benefit structures but require long term custodial care in the community. This will allow transfers to less intensive settings when appropriate in these cases.

7. Which quality measures do you most rely on to measure and improve your own quality of care?

   Baystate Medical Center relies on a combination of CMS/Joint Commission/Commonwealth of MA required measures -both process and outcome- to measure and improve our hospital based quality.

   These measures include:

   - Population-based measures of CMS IPPS -Acute Myocardial Infarction (AMI)
   - Heart failure (HF)
   - Pneumonia (PN)
   - Surgical care (SCIP)
   - Children's asthma care (CAC)
   - Coming soon ED through put CMS OPPS (outpatient surgery measures, selected cardiac measures)
   - Hospital acquired conditions (HACs)
   - Patient safety indicators (PSI)
   - Inpatient quality indicators (IQI)
   - 30 day all cause re-admission rates for AMI/HF/PN

- 30 day mortality for AMI/HF/PN
- Structural measures - registries such as Society for Thoracic Surgery/ACC, Get with the Guidelines /Outcome/Coverdell Stroke care
- Nursing sensitive indicators
- Mandatory state reporting
- Stroke Care for Primary Stroke Service

We also report to NHSN on selected hospital acquired infections as well as on Patient experience as part of the HCAHPS program.

Additionally, we review our in house mortality, infection rates and other potentially preventable events for improvement opportunities using the IHI Global Trigger tool and the UHC Patient Safety Net Safety reporting system.

8. We found that there is substantial price variation occurring for several types of health care services (although for some more than others), but that the wide variation of prices for hospital care does not appear to represent any corresponding gain in quality based on the existing quality measures that we were able to use in this analysis. Does your organization believe that price is correlated with quality? What role do you think quality should play in determining prices, and does the health care community currently collect the right types of quality measures?

We believe that price is correlated with quality and that the current measures for quality in terms of processes and outcomes do not completely account for the "value" that is provided to the community. Massachusetts hospitals, in particular, as a group have done extremely well with regard to current measures and in other new measures such as "Hospital Acquired Conditions"

It is not just the currently available Hospital Quality measures that must be considered in the overall value equation. For starters, the measures we see used on "Hospital Compare" and other publicly available sites, were intended to be core starter sets to make sure organizations had infrastructure and ability to work on improvement. Initially there was an ability to see differences in care using these measures. Today many of these measures are being "retired" as they have "topped off" as most organization are able to achieve quality in the reliability rates in the high 90 percentage points. The outcome measures also suffer from risk adjustment issues that make comparing outcomes very difficult, and as a result, almost all outcomes across all hospitals statistically fall into the "as expected" category. There are other measures that have been approved by the NQF that we may want to consider that may do a better job at distinguishing organizations. A measure such as "Failure to Rescue", for example, is one that may be a candidate and would need to be investigated. In addition, using real clinical data such as data from the Society of Thoracic Surgery (STS) databases for cardiac procedures and the National Surgical Quality Improvement Program (NSQIP) may help to distinguish hospitals based on quality.

We must recall that quality is defined not only with processes and outcomes but is also measured by structural elements. A hospital that is responsible for Trauma for a community with a level 1 trauma center or one that is responsible for caring for sick neonates with a level III NICU must be supported as part of the "price". Traditional reimbursements fail to

compensate for the full cost to maintain such programs. Having the ability to staff a 24/7 Heart Attack Center or Stroke Center for instance must also be part of the equation.

Finally we must also recognize the additional costs for educating the next generation of physicians. Here in western Massachusetts, our teaching hospital has trained over one third of all the primary care doctors in our community. Without this educational support, our community would have a larger shortage of primary physicians.

9. We found that for many inpatient DRGs, a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please provide your organization's reaction to these findings.

Based on information published by DHCFP and others, Baystate Medical Center is a low cost hospital with low price (payment rates) per inpatient DRG when compared to other hospitals in our peer group. Our reaction to the DHCFP findings is based on a number of complicated influences that start with the fact that state government underpayment is a key driver of escalating health care prices. We recommend that government payers increase payment levels to adequately cover costs of care so that Mass Hospitals might not be so reliant upon negotiating higher payment rates from non-government payors. The fact that large, reputable (Boston area) teaching hospitals have greater opportunities to shift portions of this burden to private insurance payers is not a surprise to us. It is also clear that the patients choosing those higher priced hospitals do so based on a supposed higher quality of care, while information based on "outcomes" shows that our results at Baystate Medical Center are as good or better. This is a complicated issue that we believe indicates the Commonwealth of Massachusetts needs to provide additional analysis with an emphasis on providing quality of care information to the general public in order to help shift volume to lower price hospitals such as Baystate.

10. What tools should be made available to consumers to make them more prudent purchasers of health care?

Hospitals in Massachusetts and around the nation responded to public calls for increased transparency about the quality of hospital care through the creation of the Hospital Quality Alliance (HQA) in 2002. The HQA is a national public-private collaboration that is committed to making meaningful and easily understood information about hospital performance accessible to the public and to informing and encouraging efforts to improve quality. In addition to hospitals, HQA includes organizations that represent consumers, doctors and nurses, employers, accrediting organizations, and Federal agencies (see www.hospitalqualityalliance.org).

A cornerstone of the HQA collaboration is Hospital Compare (www.hospitalcompare.hhs.gov), a website of the U.S. Department of Health and Human Services that publicly reports on hospital performance based on consistently applied measurement and data reporting rules. Hospital Compare displays rates for Process of Care measures that show whether or not hospitals provide some of the care that is recommended for patients being treated for a heart attack, heart failure, pneumonia, asthma (children only) or patients having surgery. Hospitals voluntarily submit de-identified data about the treatments their patients receive for these conditions. The data include patients with Medicare, those enrolled in Medicare health plans, and those who don't have Medicare.

This information helps consumers compare the quality of care provided in the hospitals that agree to submit data on the quality of certain services they provide for certain conditions. This quality information not only helps consumers make good decisions about their health care, but also encourages hospitals to improve the quality of health care they provide.

11. What are the advantages and disadvantages of complete price transparency (e.g., consumers being able to see what prices are paid by carriers to different providers for different services) from your organization's perspective? What about complete quality transparency?

    With regard to making data public, BMC is a supporter of meaningful consumer transparency. We fully embrace quality improvement efforts and believe there is a place for disclosure to the consumer of quality information so long as it is clinically valid and understandable to the consumer. However, we question both the usefulness to the consumer and the fairness to the individual hospital of the disclosure to the public of reimbursement rates paid by each carrier to a hospital. Consumers do not have a direct "out-of-pocket" expenditure equal to the amount paid to the hospital. Therefore, we question how this disclosure will impact consumer behavior. For hospitals, the comparison of amounts negotiated with non-governmental payers between hospitals may not necessarily be directly related to any true 'cost' differences. As we have indicated earlier, governmental payments are not covering the costs of the services provided to their patients and therefore, in order to be financially viable, hospitals must make up for this through their negotiations with commercial payers. Hospitals are in different positions related to this issue and therefore without a resolution, which would level the playing field, we believe it is confusing to disclose reimbursement information to the public.

12. Before your organization decides to acquire new service lines, capacity, or major equipment, does it consider the current capacity of nearby providers? What do you feel the state's role should be in health care resource planning (beyond or including its current Determination of Need process)?

    Baystate has a sophisticated, integrated strategic and financial planning process that ensures that our decisions are developed with discipline.

    Strategic decisions are made by Baystate's Board of Directors in collaboration with the system's senior leadership team, clinical/administrative management team, relevant service line leaders and supporting Divisions, including Strategy and External Relations and Finance/Financial Analysis.

    Decisions on future healthcare services and other opportunities are based on:

    - Consistency with our Vision and Integrated Strategic and Financial Plan,
    - Community needs including needs assessments, research surveys, focus groups and feedback from community providers, partners, and current/former patients and customers,
    - Healthcare environmental trends including those related to health care reform at the national and state levels, shifts in technology and demand (use rates, utilization trends etc.), and
    - Internal analyses, including benefit/risk and financial investment.

Opportunities for collaborative service delivery, such as joint ventures, co-management agreements and contractual arrangements, are given full consideration.

In that the state plays a major role in the delivery and financing of health care and public health in Massachusetts, we feel the role of the state should include:

- Collaborating with health care providers in the development of new models and provision of resources for advancing key aspects of health care reform;
- Assessing unmet public health needs, building local health infrastructure and capacity, and providing resources (including grants) for meeting unmet needs; and
- Facilitating the simplification of administrative and reporting requirements by providers to state agencies.

13. How ready does your organization feel it is to join, affiliate with, or become an Accountable Care Organization (ACO)? Please explain.

    a. Is your organization interested in joining a Medicare Shared Savings ACO, as recently outlined by the Centers for Medicare and Medicaid Services (CMS)?

    b. If your organization doesn't feel ready to join any type of ACO, what types of supports or resources would it need to be able to join one?

Baystate Health (BH) is well positioned to provide high quality managed care through an organized, coordinated approach to population management that can provide a viable and sustainable path to controlling medical costs. BH includes three hospitals: Baystate Medical Center, an academic medical center, Baystate Franklin Medical Center and Baystate Mary Lane Hospital, community hospitals, which are focused on high quality of care. Drawing on the work of the Institute for Healthcare Improvement (IHI) and Don Berwick, M.D., realizing the "Triple Aim" vision permeates our organization. BH has implemented several programs that have reduced readmissions, improved value through bundled care, and improved hospital quality and reduced complications.

Health New England (HNE) is an IPA-model HMO that started as a commercial insurer in 1985. Presently, Baystate Health owns 97% of HNE, which serves 120,000 members in Western Massachusetts. HNE serves the (1) commercial market, including individual and small group products; (2) provides Medicare Advantage products to eligible individuals; and (3) as of July 1, 2010, provides coverage to MassHealth eligible individuals in Western Massachusetts through its HNE Be Healthy℠ managed Medicaid product. Consistent with its parent, HNE's mission is to serve all the people in Western Massachusetts through innovative and cost effective care management. The National Committee for Quality Assurance (NCQA) has ranked HNE one of the top ten health plans in the country.

Baycare Health Partners (Baycare®) is a physician-hospital organization comprised of the three Baystate Health hospitals in about 200 medical practices in Hampden, Hampshire and Franklin counties. Our mission is to improve the quality, safety, efficiency and sustainability of health care in our community. Our proven clinical integration programs support and further this mission.

Critical to the success of patient-centered care and the transition from a fee-for-service to comprehensive payment model is the integration of health care across the continuum of the

patient experience. Care must be better coordinated, rather than fragmented, as patients navigate through the various sites of care including pharmacies, physician offices, diagnostic & imaging centers, ambulatory procedure centers, acute care hospitals, and post acute facilities. Providers of care must collaborate to ensure the best outcome for their patients. Variations in practice patterns must be addressed to improve quality and reduce health care costs.

To this end, Baystate Health, Health New England, and Baycare® are collaborating to develop an integrated health care model. Case and care managers from all three BH entities already cooperate in a number of ways, but to assure optimal use of these resources, BH leadership has engaged a consultant to assist in this system-wide initiative that will result in new and improved processes, systems, activities and models. These improvements will better position us to deliver accountable care in the evolving health care environment. This multifaceted approach will encompass:

- *Population Management*: A series of activities performed for a population of patients including: health risk assessment, risk stratification and predictive modeling, registry assignment, outreach, and benefit plan design.
- *Care Models*: Condition- or disease-specific care delivery models developed through consensus and involving shared responsibility across providers.
- *Case Management*: The collaborative management of options and services available to patients with a high disease burden or those requiring high intensity of care and/or high cost care.
- *Care Coordination*: The intentional facilitation of care across the delivery continuum to ensure seamless value-enhancing transitions and a uniform care experience.

We are well positioned to assume a leading role in the accountable care arena. Our physician network encompasses a broad range of primary care and specialty physicians. Our Patient-Centered Medical Home (PCMH)/payment prototype positions us well to manage costs and quality under a comprehensive payment system. In addition to more than a decade of experience with embedded, practice-based care management, we have several years experience with measuring, analyzing, and communicating quality performance to our physician practices.

Baystate Health is actively considering applying to become a Pioneer ACO, and whether our accountable care journey culminates in a formal structure contracted through CMS or remains an ACO in the private sector, we have the leadership commitment, infrastructure and provider support to succeed.

14. Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What have been the effects in terms of health care cost, service quality, and patient outcomes?

Baystate Medical Center launched a bundled care prototype for total hip replacement patients on January 1, 2011. We are collaborating with Health New England, New England Orthopedic Surgeons, and Baystate Visiting Nurse Association & Hospice to provide care for this patient population encompassing 30 days before- to 90 days after the procedure. To date we have enrolled 16 patients in the 'bundled care prototype'. We have been able to

lower costs by roughly $2,000 per patient while achieving 100% performance in surgery process measures. We observed improved patient satisfaction, no re-hospitalizations, and no patient harm, including no hospital acquired infections (urinary tract and surgical site), venous thromboembolism, or pressure ulcers.

We are expanding our Bundled care prototypes to 3 other populations including a chronic care model for asthma and 2 other elective surgical procedures.

15. Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

Additional key drivers of escalating health care costs that should be examined in the future years include end of life care, an aging population, changing demographics, higher survival rates from chronic disease and the explosion of technology and new drugs. In the future the creation of "Medical Homes" and "Accountable Care Organizations" may be beneficial in addressing the cost and quality of care for a defined population.

Government (Medicare and Medicaid) payments for services to hospitals, which generally do not cover costs, need to be addressed. Currently, hospitals must try to make up this "shortfall" by negotiating higher rates from private insurers.

16. Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

We recommend that government payers increase payment levels to cover costs of care so that the burden of the shortfall is not shifted to the commercial payers. In order to offset this payment shortfall we must negotiate higher payment rates from our non-governmental payers. Therefore, if the government payers would increase their rates to cover the costs and provide a margin for our ability to invest in new capital technologies this would likely result in lower price increases to commercial payers.

Specific ideas to increase government payments include:

- Increase Medicare payment rates for certain outpatient services where payments currently do not cover costs
- Restore Medicaid reimbursement for graduate medical education.
- Begin Medicaid reimbursement for allied medical professional education.
- Ensure adequate and appropriate payment rates from MassHealth (e.g., Statewide Payment Amounts per Discharge do not correspond to current case mix) and Health Safety Net for services delivered by hospitals.

Other ideas for governmental intervention include:

- Develop and implement a statewide strategy to recruit primary care physicians and expand primary care capacity in the state.
- Address primary care access problems by encouraging alternative care sites and after-hours options to hospital emergency departments.

Attorney General's Office Questions and Baystate Medical Center's Testimony

1. Please explain and submit a summary table showing your annual operating margins (profit or loss) from 2005 to 2010 broken down by your commercial, government, and all other business (and please identify the carriers or programs included in each of these three aggregate margins). Please explain and submit supporting documents to show whether and how your revenue and margins are different for commercial carriers for your business operated through HMO, PPO, POS agreements, including any agreements subject to a global per member per month budget.

Baystate Medical Center Operating Margin (in millions)						
	FY 2005	**FY 2006**	**FY 2007**	**FY 2008**	**FY2009**	**FY2010**
Governmental	($8.5)	($9.7)	($10.7)	($4.0)	($21.6)	($18.6)
Commercial	$43.3	$54.8	$53.2	$45.3	$72.7	$68.3
Other Business	$1.9	($1.8)	$5.4	$7.2	$12.1	$8.9
Total	$36.7	$43.3	$47.9	$48.5	$63.2	$58.6

BMC's cost accounting system calculates the annual operating margin by patient and then aggregates all patients into their primary payor to determine a payor's operating margin. We calculate the expected reimbursement for each patient based on the services received and the associate primary payor's contract payment terms. We include both direct and indirect cost in our margin calculations. We include other operating revenue in our margin calculations. We include non-patient revenue.

Governmental Includes:

Medicare
Massachusetts Medicaid

Commercial Includes:

Aetna Insurance
Blue Cross of Massachusetts
Boston Medical Center Health Net
CHAMPUS
CIGNA Health Plan
CTCare of Massachusetts
GIC Indemnity Plan
Harvard Pilgrim Health Plan
Health New England
Mass Behavioral Health Partnership
Neighborhood Health Plan
Network Health
Tufts Associated Health Plan
United Health Care

Various Automobile Insurance Plans
Various Other Commercial Insurance Plans
Various Workers Compensation Plans

Other Business includes miscellaneous transactions relating to prior years.

Baystate Medical Center FY2010 Commercial HMO, PPO & POS Operating Revenue and Margin (in millions)		
	Revenue	**Margin**
HMO	$285.4	$30.7
PPO	$135.4	$34.9
POS	$ 9.6	$ 1.3

BMC has no significant agreements subject to a global per member per month budget.

HMO, PPO and POS contracts have different rate structures. Rate differentials may not equate to hospital cost differentials.

2. Please explain and submit a summary table showing your commercial operating income trend from 2005 to 2010, and how that trend results from: (1) changes in the unit price of health care services or procedures, (2) changes in utilization, and (3) changes in other factors, such as changes in mix of services, mix of location of services, member demographics, and plan design.

Commercial Operating Income Trend (in millions)	**Average Annual Percentage Change**	**Cumulative Percent Change**	**Impact**
FY2005 Income			$407.9
FY2006 – FY2010 Change in Unit Price	1.31%	6.57%	$ 26.8
FY2006 – FY2010 Change in Utilization	3.81%	19.04%	$ 77.6
FY2006 – FY2010 Change in Other Factors	.03%	.13%	$ .5
FY2010 Income			$512.8

Commercial Operating Income represents payments we receive from commercial payers before offsetting related costs of patient care.

Our average annual increase in commercial operating income of 5.14% approximates our average annual cost increases of 4.79% (see our response to DHCFP question #2).

3. Please explain and submit a summary table showing your gross operating expense trend for medical services (excluding research and other non-medical cost centers) from 2005 to 2010, and how that trend results from: (1) facility costs including rental, maintenance, construction, and depreciation, (2) equipment costs including rental, maintenance, purchase or depreciation, (3) non-physician labor costs, (4) physician labor costs, and (5) other factors.

Baystate Medical Center	Average Annual Change FY2005 – FY2010
Gross Operating Expense (excluding research)	4.77%
Components	
Facility Costs	(.9%)
Equipment Costs	1.15%
Non-Physician Labor Costs	7.39%
Physician Labor Costs	6.26%
Other Factors (Including Supply Cost)	2.95%

As noted above, fiscal years 2009 and 2010 annual increases were only 2.5% and 2.29% respectively.
We do not have any material non-medical costs and therefore, we've only excluded research in the above table.
See our wage increase response to DHCFP question #2 which relates to non-physician labor cost trends. The increase in physician labor cost relates to contract physician labor.

I am legally authorized and empowered to represent Baystate Medical Center for the purposes of this testimony. I hereby certify under the pains and penalties of perjury that, under my direction, BMC has made a diligent effort to respond to the foregoing questions, and that, to the best of my knowledge, information, and reasonable belief, the foregoing answers are true and correct.

Sincerely,

Dennis W. Chalke
Sr. VP, CFO and Treasurer, Baystate Health